Complete Summary

GUIDELINE TITLE

First prescription of the combined oral contraception.

BIBLIOGRAPHIC SOURCE(S)

Faculty of Family Planning and Reproductive Health Care Clinical Effectiveness Unit. First prescription of combined oral contraception. London (UK): Faculty of Family Planning and Reproductive Health Care; 2007 Jan. 21 p. [186 references]

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: First prescription of combined oral contraception. J Fam Plann Reprod Health Care 2003 Oct;29(4):209-22. [128 references] PubMed

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Unintended pregnancy

GUIDELINE CATEGORY

Counseling
Evaluation
Management
Prevention

Risk Assessment
Treatment

CLINICAL SPECIALTY

Family Practice
Internal Medicine
Obstetrics and Gynecology
Preventive Medicine

INTENDED USERS

Advanced Practice Nurses
Nurses
Patients
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

- To provide evidence-based recommendations and good practice points for clinicians advising women considering a first prescription of combined oral contraception
- To update and replace previous Faculty guidance

TARGET POPULATION

Women considering their first prescription of combined oral contraception (COC)

Note: Does not apply to women using COC for use as treatment of other conditions where the risk benefit profile may be different.

Note: Readers are referred to other Guidance documents from the Faculty of Family Planning and Reproductive Health Care Clinical Effectiveness Unit that provide further information about the use of COC in specific circumstances, namely: young women, women aged over 40 years, women who are breastfeeding, women with inflammatory bowel disease, use of contraception outside the terms of the product licence and drug interactions with hormonal contraception.

INTERVENTIONS AND PRACTICES CONSIDERED

1. Clinical history including medical, sexual, family, and drug history, details of reproductive health, assessment of cardiovascular risk factors, migraines and previous contraceptive use
2. Blood pressure measurement, body mass index assessment, screening for sexually transmitted infection
3. Assessment of medical eligibility for contraceptive use
4. Counseling and educating patients on risks and benefits of oral combined contraception (COC*)
5. Advising women when to start COC in different circumstances, helping them to choose their first COC, and giving instructions regarding missed pills and situations where efficacy may be reduced

6. Prescribing COC (refer to the original guideline document for the quick reference guide to COC prescribing)
7. Follow-up visits

*COC refers to monophasic pills containing 20 to 35 micrograms ethinylestradiol in combination with a progestogen.

MAJOR OUTCOMES CONSIDERED

Risks and benefits of combined oral contraception use

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Electronic searches were performed for: MEDLINE (CD Ovid version) (1996-2006); EMBASE (1996-2006); PubMed (1996-2006); the Cochrane Library (to April 2006), and the US National Guideline Clearing House. The searches were performed using relevant medical subject headings (MeSH), terms, and text words. The Cochrane Library was searched for systematic reviews, meta-analyses, and controlled trials relevant to combined oral contraception. Previously existing guidelines from the Faculty of Family Planning and Reproductive Health Care (FFPRHC), the Royal College of Obstetricians and Gynaecologists (RCOG), the World Health Organization (WHO) and reference lists of identified publications were also searched.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Not Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not stated

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Selected key publications were appraised according to standard methodological checklists before conclusions were considered as evidence. Evidence was graded using a scheme similar to that adopted by the Royal College of Obstetricians and Gynaecologists (RCOG) and other guideline development organizations.

Evidence tables relating to this Guidance are available on request from the Clinical Effectiveness Unit. These summarise relevant published evidence on first pill prescription, which was identified and appraised in the development of this Guidance.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The Draft One Guidance document is written, providing recommendations and good practice points based on the literature review. The Clinical Effectiveness Unit must take overall responsibility for writing the Guidance document. The Multidisciplinary Group and other peer reviewers should highlight inconsistencies and errors or where the text is incomprehensible.

A Multidisciplinary Group Meeting is held, comprising stakeholders and including service user representation, representation from the Faculty of Family Planning and Reproductive Health Care (FFPRHC) Education Committee and, where possible, representation from the FFPRHC Clinical Effectiveness Committee (CEC) and FFPRHC Council. A one-day meeting is held in Aberdeen with the Multidisciplinary Group to discuss the Draft One Guidance document.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Grades of Recommendations

A: Evidence based on randomised controlled trials

B: Evidence based on other robust experimental or observational studies

C: Evidence is limited but the advice relies on expert opinion and has the endorsement of respected authorities

Good Practice Point: Where no evidence exists but where best practice is based on the clinical experience of the multidisciplinary group

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The Draft Two Guidance document is peer reviewed by the Multidisciplinary Group and the Faculty of Family Planning and Reproductive Health Care Clinical Effectiveness Committee (FFPRHC CEC). All written feedback on the Draft Two Guidance document is tabulated and the Clinical Effectiveness Unit (CEU) response to these comments is outlined. The Draft Three Guidance document is prepared based on written feedback and is sent to the Multidisciplinary Group and the FFPRHC CEC. Only minor comments can be accepted at this stage. The Final Guidance document is published by the FFPRHC. Proofreading of the Guidance is then performed by three members of the CEU team independently and comments collated and sent back by the Unit Director. A PDF version of the Guidance is made available on the FFPRHC website.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Definitions of the grades of recommendation, based on levels of evidence (A-C, Good Practice Point), are provided at the end of the "Major Recommendations" field.

Evidence-Based Information for Clinicians

Medical History Before a First Prescription of Combined Oral Contraception (COC)

1. In order to advise on eligibility for COC use, clinicians should take a clinical history including: medical conditions (past and present), drugs use (prescription, non-prescription and herbal remedies) and family history (**Good Practice Point**).
2. When considering a first prescription of COC, clinicians should specifically enquire about migraine and cardiovascular risk factors (smoking, obesity, hypertension, thrombophilia, previous venous thromboembolism and hyperlipidaemia) (**Good Practice Point**).
3. User preference and individual concerns about COC use should be addressed (**Good Practice Point**).

   (See Table 2 of the original guideline document for the UK Medical Eligibility Criteria [UKMEC] for combined oral contraceptive use.)

Age

4. COC can be used from the menarche to age 50 years if there are no other risk factors (**Grade C**).

Smoking

5. Clinicians should be aware that there is a very small increased risk of myocardial infarction (MI) with current COC use in *non-smokers* which increases further for *smokers* (**Grade B**).
6. Use of COC by women aged ≥35 years who smoke is not recommended (**Grade B**).
7. Use of COC may be considered by women aged ≥35 years who have stopped smoking for ≥1 year (**Grade C**).

Obesity

8. Use of COC by women with a body mass index (BMI) ≥35 is associated with an increased risk of myocardial infarction (MI) and venous thromboembolism (VTE) and is not generally recommended (**Grade B**).

Hypertension

9. Use of COC is not generally recommended when blood pressure is consistently >140 mmHg systolic and/or >90 mmHg diastolic (**Grade C**).

Venous Thromboembolism

10. Use of COC by women with a personal history of VTE or known thrombogenic mutations is not recommended (**Grade C**).
11. Clinicians should be aware that the relative risk of VTE with COC use can increase up to five-fold, but in absolute terms the risk is still very low (**Grade B**).
12. A thrombophilia screen is not recommended routinely before prescribing COC (**Grade C**).
13. For women with a family history of VTE, a negative thrombophilia screen does not necessarily exclude all thrombogenic mutations (**Grade C**).
14. The interpretation of a thrombophilia screen should be undertaken in consultation with a haematologist or other expert and in combination with a detailed family history (**Good Practice Point**).

Stroke

15. Clinicians should be aware that there is a very small increase in the absolute risk of ischaemic stroke with COC use (**Grade B**).

Migraine

16. Use of COC by women of any age who have migraine with aura is not recommended (**Grade B**).
17. Use of COC by women ≥35 years of age who have migraine without aura is not generally recommended (**Grade B**).

Breast Cancer

18. Clinicians should be aware that any increased risk of breast cancer with COC use is likely to be small, is in addition to background risk, and is reduced to no increased risk 10 years after stopping COC use (**Grade B**).

Cervical Cancer

19. Clinicians should be aware that there may be a very small increase in the risk of cervical cancer with COC use, which increases with increasing duration of use (**Grade B**).

Potential Drug Interactions

20. Clinicians should consider the possibility of drug interactions when prescribing COC (**Good Practice Point**).
21. Liver enzyme-inducing drugs may reduce the efficacy of COC; therefore, if they are to be used long term, alternative contraceptives that are unaffected by enzyme-inducing drugs should be considered (**Grade C**).
22. If, after counselling, women using liver enzyme-inducing drugs still wish to use COC then a regimen with at least 50 micrograms EE should be used. In addition, barrier contraception is recommended while taking the liver enzyme-inducers and for 28 days after they are stopped (**Good Practice Point**).
23. A woman taking long-term non-liver enzyme-inducing antibiotics (≥3 weeks) does not require additional contraceptive protection when starting COC (**Grade C**).
24. Women using COC who are prescribed a short course (<3 weeks) of non-liver enzyme-inducing antibiotics should be advised to use additional contraceptive protection while taking the antibiotic and for 7 days after the antibiotic is stopped (**Grade C**).

Potential Non-Contraceptive Benefits to Be Considered

Dysmenorrhoea and Menorrhagia

25. Clinicians should be aware that menstrual pain and blood loss may be reduced with COC use (**Grade C**).

Ovarian Cysts

26. Clinicians should be aware that the incidence of functional ovarian cysts and benign ovarian tumours is reduced with COC use (**Grade B**).

Ovarian and Endometrial Cancer

27. Clinicians should be aware that there is at least a 50% reduction in the risk of ovarian and endometrial cancer with COC use which continues for 15 or more years after stopping (**Grade B**).

Colorectal Cancer

28. Clinicians should be aware that COC use is associated with a reduction in the risk of colorectal cancer (**Grade B**).

Acne Vulgaris

29. Clinicians should be aware that COCs can improve acne vulgaris (**Grade A**).

Other Relevant Information

Weight Gain

30. Clinicians should be aware that there is no evidence of additional weight gain due to COC use (**Grade A**).

Bleeding Patterns

31. Clinicians should be aware that unscheduled bleeding can occur with COC use but in the absence of missed pills, vomiting within 2 hours of pill taking, severe diarrhoea or drug interactions it is not a measure of efficacy (**Grade B**).
32. Clinicians may wish to give women advice to alter the timing of the withdrawal bleeds but should be aware that this use is outside the terms of the product licences (**Good Practice Point**).

Which Examinations Are Needed Before a First Prescription of COC?

33. A blood pressure recording should be documented for all women prior to a first prescription of COC (**Grade C**).
34. Body mass index (BMI) should be documented for all women prior to a first prescription of COC (**Good Practice Point**).

When Can COC Be Started?

35. Ideally COC should be started on the first day of menstruation but can be started up to and including Day 5 of the cycle without the need for additional contraceptive protection (**Grade C**).
36. COC can be started at any other time in the cycle if it is reasonably certain the woman is not pregnant but additional contraceptive protection, such as condoms, is required for the first 7 days (**Grade C**).

Table. When to Start Combined Oral Contraception (COC) in Different Circumstances

Circumstances for COC Start	When to Start COC	Additional Contraceptive Protection Required
Women having menstrual cycles	Start COC up to and including Day 5 At any other	None For 7 days

Circumstances for COC Start	When to Start COC	Additional Contraceptive Protection Required
	time if it is reasonably certain that she is not pregnant	
Women who are amenorrhoeic	COC can be started at any time, if it is reasonably certain she is not pregnant	For 7 days
Postpartum (not breastfeeding)	Start COC on Day 21 postpartum if vaginal delivery and no additional risk factors for VTE	None
	If she is >21 days postpartum and her menstrual cycles have returned she can start COC as for other women having menstrual cycles	None or for 7 days
	If she is >21 days postpartum and her menstrual cycles have not returned treat as amenorrhoeic	For 7 days
Postpartum (breastfeeding)	If she is >6 months postpartum and her	None or for 7 days

Circumstances for COC Start	When to Start COC	Additional Contraceptive Protection Required
	menstrual cycles have returned she can start COC as for other women having menstrual cycles (Women breastfeeding <6 weeks postpartum should not use COCs and between 6 weeks and 6 months COC can be started as for women who are postpartum and not breastfeeding – see above)	
Post-abortion	She can start COCs within 7 days of surgical or medical abortion at gestations <24 weeks	None
Switching from other hormonal methods (other than the IUS)	COC can be started immediately if she has been using her hormonal method consistently and correctly, or if it is	None

Circumstances for COC Start	When to Start COC	Additional Contraceptive Protection Required
	reasonably certain she is not pregnant. There is no need to wait for her next menstrual period	
	If her previous method was an injectable or a implant (which inhibit ovulation), she can start COC any time up to when the repeat injection is due or the implant is removed	None
Switching from a non-hormonal method (other than the IUD)	Start COC up to and including Day 5 of the menstrual cycle At any other time if it is reasonable certain that she is not pregnant	None For 7 days
Switching from IUD or IUS	COC can be started up to and including Day 5 after the start of menstrual bleeding. IUD/IUS can be removed	None

Circumstances for COC Start	When to Start COC	Additional Contraceptive Protection Required
	at that time	
	COC can be started at any other time, if it is reasonably certain she is not pregnant. Ideally the IUS/IUD can provide contraceptive protection until seven or more pills have been taken. The IUS/IUD can then be removed. If the IUD/IUS is removed at the time of starting COC then additional contraception is required for 7 days as ovulation still occurs for women using intrauterine methods	For 7 days

COC, combined oral contraception; IUD, intrauterine device; IUS, intrauterine system; VTE, venous thromboembolism.

Which Pill Is Suitable for Women Being Given a First Prescription of COC?

37. A monophasic COC containing 30 micrograms EE with norethisterone or levonorgestrel is a suitable first pill (**Grade C**).

What Follow-Up Arrangements Are Appropriate for Women Being Given a First Prescription of COC?

38. A follow-up visit 3 months after a first prescription of COC allows an assessment of blood pressure, further instruction and assessment of any problems (**Good Practice Point**).
39. In the absence of special problems, women can be given up to 12 months' supply of COC at follow-up and encouraged to return at any time if problems arise (**Grade C**).

Evidence-Based Information for Women

What Information Should Be Given to All Women When Receiving a First Prescription of COC?

Potential Harms and Benefits

40. At first prescription of COC all women should be informed that:
    - COC use is safe for the majority but can be associated with rare but serious harms
    - There is a small increase in the risk of blood clots with COC use
    - There is a very small increase in the risk of heart attack and stroke with COC use
    - Any increased risk of breast cancer is likely to be small and returns to no increased risk 10 years after stopping COC
    - There may be a very small increase in the risk of cervical cancer that increases with increasing duration of use
    - The risk of ovarian and endometrial cancer is halved with COC use and this continues for at least 15 years after stopping (**Grade B**).

How To Take the Pill

41. Women should be advised to start COC on the first day of menstruation but it can be started up to and including Day 5 of the cycle without the need for additional contraceptive protection (**Grade C**).
42. Women can start COC at other times in the menstrual cycle if is reasonably certain that they are not pregnant but additional contraceptive protection is required for the first 7 days (**Grade C**).
43. Women should be encouraged to take one pill every day, at around the same time, for 21 consecutive days (**Grade C**).
44. Women should be advised that if all pills are taken consistently and correctly a COC is >99% effective at preventing pregnancy, even during the routine seven hormone-free days (**Grade B**).
45. Missing pills is not encouraged but women can be reassured that if one pill in the packet is missed at any time then contraceptive protection is not lost. If more pills are missed and they are unsure what to do they should seek help (**Grade C**).

Situations Where Efficacy May Be Reduced

46. Women should be advised that if vomiting occurs within 2 hours of taking COC another pill should be taken as soon as possible (**Grade C**).
47. Women should be informed that if they are prescribed antibiotics (non-liver enzyme-inducing) then additional contraceptive protection such as condoms should be used during the treatment and for 7 days after the antibiotic is

stopped. If fewer than seven active pills are left in the pack after antibiotics are finished the woman should omit the pill-free interval (or discard any inactive pills). After using the same antibiotic for ≥3 weeks additional contraception is no longer required (**Grade C**).

Other Information

48. Women should be encouraged to continue with the first COC for at least 3 months before considering an alternative (**Good Practice Point**).
49. Women should be given information on symptoms, which should prompt immediate medical consultation such as warning signs of VTE and new headache (**Good Practice Point**).
50. Women can be advised about practising safer sex with the use of condoms in addition to COC (**Good Practice Point**).
51. Women should be provided with appropriate written and verbal instructions regarding rules for missed pills, vomiting within 2 hours of taking a pill, severe diarrhoea, the use of new medication and when to seek help (**Good Practice Point**).

Definitions

Grades of Recommendation based on levels of evidence as follows:

A: Evidence based on randomised controlled trials (RCTs)

B: Evidence based on other robust experimental or observational studies

C: Evidence is limited but the advice relies on expert opinion and has the endorsement of respected authorities

Good Practice Point: Where no evidence exists but where best practice is based on the clinical experience of the multidisciplinary group

CLINICAL ALGORITHM(S)

An algorithm is provided in the original guideline document on advice for women missing combined oral contraceptive pills.

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations" field).

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

General Potential Benefits

- Improved knowledge of the steps to be taken before providing a woman with her first prescription for combined oral contraception (COC)
- Consistent and correct use of COC provides effective contraception

Specific Benefits

Non-contraceptive Benefits of COC

- Reduction in menstrual pain and blood loss
- Reduction in incidence of functional ovarian cysts and benign ovarian tumours, endometrial cancer, and colorectal cancer
- Reduction in the risk of ovarian and endometrial cancer
- Improvement in acne vulgaris

POTENTIAL HARMS

Risks of Combined Oral Contraception (COC)

There is a small increased risk of:

- Breast cancer
- Cervical cancer, (increases with duration of use)
- Blood clots
- Heart attack and stroke
- Breast cancer, returns to no increased risk 10 years after stopping COC
- Unscheduled bleeding

Liver enzyme-inducing drugs may reduce the efficacy of COC.

Risks associated with COC generally outweigh the benefits in the following circumstances:

- Breastfeeding - between 6 weeks and 6 months postpartum and fully or almost fully breastfeeding
- Postpartum - <21 days postpartum
- Smoking - aged ≥35 years and smoking <15 cigarettes per day, or stopped smoking <1 year ago
- Obesity - body mass index 35 to 39 kg/m^2
- Cardiovascular disease - multiple risk factors for arterial cardiovascular disease
- Hypertension - elevated blood pressure >140 to 159 mmHg systolic or >90 to 94 mmHg diastolic
- Family history of venous thromboembolism in a first-degree relative aged <45 years
- Immobility (unrelated to surgery) - e.g., wheelchair use, debilitating illness
- Known hyperlipidaemias - e.g., familial hypercholesterolaemia
- Migraine headaches - without aura in women aged ≥35 years; or a past history of migraine with aura at any age
- Breast disease - past history of breast cancer and no evidence of recurrence for 5 years; carriers of known gene mutations associated with breast cancer (e.g., BRCA1);undiagnosed mass

- Diabetes - with nephropathy/retinopathy/neuropathy; or other vascular disease or diabetes of >20 years' duration (category given will depend on disease severity)
- Gallbladder disease - symptomatic medically treated or current
- History of cholestasis - past COC-related
- Cirrhosis - mild compensated disease
- Drugs which induce liver enzymes - e.g., rifampicin, rifabutin, St John's Wort, griseofulvin and certain anticonvulsants (i.e., phenytoin, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine)

CONTRAINDICATIONS

CONTRAINDICATIONS

According to the UK Medical Eligibility Criteria for combined oral contraceptive use, combined oral contraception should not be used in the following circumstances:

- Breastfeeding - <6 weeks postpartum
- Smoking - aged ≥35 years and smoking ≥15 cigarettes per day
- Obesity - body mass index ≥40 kg/m^2
- Cardiovascular disease - multiple risk factors for arterial cardiovascular disease
- Hypertension - blood pressure ≥160 mmHg systolic and/ or ≥95 mmHg diastolic; or vascular disease
- Venous thromboembolism - current (on anticoagulants) or past history
- Major surgery with prolonged immobilisation
- Known thrombogenic mutations
- Current and history of ischaemic heart disease
- Stroke
- Valvular and congenital heart disease - complicated by pulmonary hypertension, atrial fibrillation, history of subacute bacterial endocarditis
- Migraine headaches - with aura at any age
- Gestational trophoblastic neoplasia - when human chorionic gonadoptropin (hCG) is abnormal
- Breast disease - current breast cancer
- Diabetes - with nephropathy, retinopathy, neuropathy or other vascular disease, or diabetes of >20 years' duration (category given will depend on disease severity)
- Viral hepatitis - active disease
- Cirrhosis - severe decompensated disease
- Liver tumours - benign and malignant
- Raynaud's disease - secondary with lupus anticoagulant and thus a tendency to thrombosis

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

IMPLEMENTATION TOOLS

Staff Training/Competency Material

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

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ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2003 Oct (revised 2007 Jan)

GUIDELINE DEVELOPER(S)

Faculty of Sexual and Reproductive Healthcare - Professional Association

SOURCE(S) OF FUNDING

Faculty of Sexual and Reproductive Healthcare

GUIDELINE COMMITTEE

Clinical Effectiveness Committee

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Clinical Effectiveness Unit (CEU): Dr Susan Brechin (Senior Lecturer/Director of the CEU); Gillian Stephen (ECU Research Assistant), and Lisa Allerton (CEU Research Assistant)

Clinical Effectiveness Committee: Dr Suzanne Burgess (Senior Doctor in Reproductive Health Care, Croydon Primary Care Trust), Dr Joan Burnett (Associate Specialist, Square 13 Contraceptive and Reproductive Health Service, Aberdeen), Dr Lesley Craig (Associate Specialist, Square 13 Contraceptive and Reproductive Health Service, Aberdeen), Dr Rachel D'Souza (Associate Specialist, Margaret Pyke Centre, London), Dr Judith Graham (Staff Grade, The Sandyford Initiative, Glasgow; Faculty of Family Planning Education Committee Member), Professor Philip Hannaford (NHS Grampian Professor of Primary Care, University of Aberdeen), Dr Connie Smith (Co-Director, Westside Contraceptive Services, London) and Dr Sarah Wallage (Consultant in Sexual and Reproductive Health Care, Aberdeen)

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: First prescription of combined oral contraception. J Fam Plann Reprod Health Care 2003 Oct;29(4):209-22. [128 references] PubMed

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the Faculty of Sexual and Reproductive Healthcare Web site.

Print copies: Available from the Faculty of Sexual and Reproductive Healthcare, 27 Sussex Place, Regent's Park, London NW1 4RG

AVAILABILITY OF COMPANION DOCUMENTS

Discussion points and questions for the first prescription of combined oral contraception developed by the Faculty of Sexual and Reproductive Healthcare are available at the end of the original guideline document.

Electronic copies: Available in Portable Document Format (PDF) from the Faculty of Sexual and Reproductive Healthcare Web site.

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI on July 5, 2005. This summary was updated by ECRI Institute on May 13, 2008.

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